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ABSTRACT

Research literature pertaining to revictimization as a sequela to childhood sexual abuse of females is reviewed and the methodology critiqued. Inconsistent definitions of the variables and a variety of possible intervening factors make the attribution of direct causality between sexual abuse in childhood and subsequent revictimization in adulthood difficult to determine. However, adult women who are sexually victimized by others or physically abused in intimate relationships have a higher incidence of childhood sexual abuse than the general population. Women who victimize themselves through prostitution, self-injury and suicide are also more likely than females in the general population to be survivors of sexual abuse in childhood. Theories of revictimization are presented and recommendations for future research are proposed. Contains 44 references. (Author)

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REVICTIMIZATION AS A SEQUELA TO CHILDHOOD SEXUAL ABUSE OF FEMALES

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ABSTRACT

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Research literature pertaining to revictimization as a sequela to childhood sexual abuse of females is reviewed and the methodology critiqued. Inconsistent definitions of the variables and a variety of possible intervening factors make the attribution of direct causality between sexual abuse in childhood and subsequent revictimization in adulthood difficult to determine. However, adult women who are sexually victimized by others or physically abused in intimate relationships have a higher incidence of childhood sexual abuse than the general population. Women who victimize themselves through prostitution, self-injury and suicide are also more likely than females in the general population to be survivors of sexual abuse in childhood. Theories of revictimization are presented and recommendations for future research are proposed.

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REVICTIMIZATION AS A SEQUELA TO CHILDHOOD SEXUAL ABUSE OF FEMALES

Introduction

The prevalence of sexual abuse in childhood varies between 13.9 and 46 percent in clinical populations (Husain & Chapel, 1983; Bryer, Nelson, Miller & Krol, 1987; Beck & van der Kolk, 1987) and between 19 and 31 percent among non-clinical populations (Finkelhor, 1979; Russell, 1987; Finkelhor, Hotaling, Lewis & Smith, 1990). Childhood sexual victimization has been determined to be a significant trauma from which a variety of short-term and enduring psychological, sexual and relational problems can emanate (Jackson, Calhoun, Amick, Maddever & Habif, 1990; Gelinas, 1983; Briere & Runtz, 1987; de Young, 1982a). Revictimization in adulthood is an unfortunate fate for many victims of childhood sexual abuse. Most empirical studies have limited their examination of repeated victimization to simply sexual revictimization (Russell, 1987; Blume, 1990; Wyatt, Guthrie & Notgrass, 1992; de Young, 1982a). However, childhood sexual revictimization can leave survivors prepared to be revictimized on many different levels, ready to accept victimization as inevitable and even subject to participate in self-victimizing behaviors.

Current research has discovered a relationship between childhood sexual victimization and acquaintance and stranger rape, marital rape, sexual

exploitation by therapists and sexual advances by authority figures in adulthood (Russell, 1987; de Young, 1982a; Blume, 1990). Physical abuse within intimate relationships in adulthood is yet another possible form of revictimization for the survivor of childhood sexual abuse (Russell, 1987; Gelinas, 1983; Walker, 1984; Blume, 1990; Briere & Runtz, 1987). However, the most startling form of revictimization is the abuse which the victim directs toward herself by engaging in prostitution, self-injury and suicide attempts (Campagna & Poffenberger, 1988; van der Kolk, 1989; Herman & Hirschman, 1981).

Definitions and Descriptions

One obvious weakness of the empirical literature regarding both childhood sexual abuse and revictimization is the lack of consistency between definitional terms. Definitions of revictimization typically focus on either the type of assault, the period in which the abuse occurred, or the number of incidents for the victim (Wyatt et al., 1992). This review separates victimization into two distinct categories: a) revictimization by others which includes various forms of sexual abuse (acquaintance and stranger rape, marital rape, sexual exploitation by therapists, sexual advances by authority figures, exhibitionism and being forced to watch sexual acts) and physical abuse within intimate relationships, and b) self-revictimization which includes prostitution, self-injury and suicide. These distinct categories stem from examining both revictimization which occurs as a result of being harmed by another and revictimization which means suffering injury and loss due to voluntary behaviors (American Heritage Dictionary, 1982).

Further, in the literature there is no agreed upon definition of childhood sexual abuse. This review employs a definition suggested by Wyatt et al. (1992):

Child sexual abuse was defined as sexual body contact (fondling, attempted or completed vaginal, oral or anal intercourse) and noncontact (exhibitionism or observing someone masturbating) experiences before age 18 by a perpetrator more than 5 years older than the subject, or by a perpetrator of any age with incidents that were not desired or that involved coercion. (p.169)

It is evident that the relationship between the perpetrator and the victim is not included in this definition of childhood sexual abuse. Many empirical studies have focused more on the event of childhood sexual abuse than the relationship between the perpetrator and the victim, which would mean that incest victims were included in the general population of childhood sexual abuse survivors (Wyatt et al., 1992; Wyatt & Newcomb, 1990; Bryer et al., 1987; Coons, Bowman, Pellow & Schneider, 1989). In contrast, some studies were interested in the relationship between the perpetrator and the victim, so incest victims were distinguished from the general population of those sexually abused in childhood within their research (Russell, 1987; Herman & Hirschman, 1981; Blume, 1990; Jackson et al., 1990). This study is interested in revictimization as an outcome of the event of childhood sexual abuse. However, the empirical research is divided into those studies that more generally define childhood sexual abuse to include both incestuous and nonincestuous sexual abuse (Briere & Runtz, 1988; Bryer et al., 1987; Wyatt et al., 1992) and those studies that focus only upon incestuous sexual abuse (Lindberg & Distad, 1985; Russell, 1987; Herman & Hirschman, 1981). Therefore, the term childhood sexual abuse victim will be used

when the study includes both incestuous and nonincestuous sexual abuse, and the term childhood incest victim will be used when the study focuses upon contact or noncontact sexual activity between people too closely related to marry (Rosenfeld, 1979).

The upper age limits of childhood vary throughout the empirical literature from age fourteen to age eighteen (Wyatt et al., 1992; Briere & Runtz, 1987; Wyatt & Newcomb, 1990). This review will use age eighteen as the upper limit of childhood in order to encompass the breadth of the current literature.

The scope of this study was narrowed in order to provide a more focused review of the empirical literature. The majority of survivors of sexual abuse in childhood are females (Kendall-Tackett & Simon, 1988; Jaffe, Dynneson & Ten Bense, 1975; Finkelhor et al., 1990). Therefore, this study is limited to examining female victims of child abuse (Finkelhor et al., 1990; Finkelhor, 1979). In addition, self-revictimization was limited to behaviors more clearly matching the definition of revictimization as the repetitive act of suffering injury due to voluntary behaviors (American Heritage Dictionary, 1982). Therefore, self-revictimization was limited to behaviors that were either sexual in nature, such as prostitution, or clearly life endangering, such as self-injury or suicide. Self-revictimization could have included self-destructive behaviors, such as substance abuse and eating disorders, but the scope of the review had to be narrowed to more clearly self-victimizing behaviors.

Purpose of the Paper

Review of the literature supports a conclusion comparable to that of Wyatt et

al. (1992) which is survivors of childhood sexual abuse need an awareness of how their past abuse affects their current behavior, otherwise they are at risk of being revictimized. However, a paucity of research has been conducted concerning revictimization following sexual abuse to guide clinical assessment and interventions. The purpose of this paper is to offer a review of the empirical research from 1977 to 1992 regarding revictimization as a sequela to childhood sexual abuse of females. The review is structured to include theories of revictimization, methodological limitations, the comprehensive long-term effects of sexual abuse in childhood, and types of revictimization by others and self-revictimization. The review will conclude with clinical implications, a summary of the findings, and implications for future research.

Theories of Revictimization

Several theories and hypotheses have been produced to explain the apparent relationship between childhood sexual abuse and subsequent revictimization in adulthood. These range from perceiving revictimization as resulting from desensitization to abuse, as a compulsive behavioral re-enactment of the original trauma, as a response to the learned helplessness phenomenon and as a result of four traumagenic dynamics.

In the first major theory, Ginsburg, Wright, Harrell and Hill (1989) found one evident outcome of childhood sexual victimization to be the desensitization of the survivor to revictimization in adulthood. In a sample of 515 college students,

survivors of childhood sexual abuse showed diminished concern when presented with hypothetical situations similar to the sexual abuse they had reportedly experienced in childhood (Ginsburg et al., 1989). This indifference to future peril can make the sexual abuse survivor a likely target for revictimization (Hindelang, Gottfredson & Garofalo, 1978).

A second explanation for a relationship between sexual abuse in childhood and revictimization has been offered by van der Kolk (1989). He has presented a theory of personal victimization in which the sexual abuse survivor exposes herself almost compulsively to circumstances reminiscent of the original sexual trauma. He explained that sexually victimized women may attempt to neutralize their sense of hyperarousal by compulsive re-exposure to victimization of self and others. Adult survivors of sexual abuse can feel as if they are back in the original traumatizing circumstance when they encounter particular affects or external events (van der Kolk, 1989).

Peterson and Seligman (1983) proposed that revictimization may be created by a type of learned helplessness in which the victim learns through the sexual abuse that her efforts to escape are futile, thereby bringing on a sense of emotional numbness and maladaptive passivity. According to the learned helplessness theory, victims of trauma such as sexual abuse can begin to perceive bad events as caused by internal, stable and global factors which leads to a loss of personal power (Peterson & Seligman, 1983). The sexual abuse victim may become resigned to give in to subsequent victimization due to a personal sense of worthlessness, powerlessness,

emotional exhaustion and belief that she is not entitled to any treatment other than abuse (Blume, 1990). The inability of the child abuse survivor to value herself makes her vulnerable to act out her sense of unworthiness by repetitive involvement in abusive relationships (Koss & Burkhart, 1989).

A fourth theory, proposed by Finkelhor and Browne (1985), focuses on revictimization as related to four traumagenic dynamics. The first dynamic, traumatic sexualization, refers to the way in which sexual abuse can cause the victim's sense of sexuality to develop in a dysfunctional manner, which may lead to inappropriately sexualized behavior and subsequent revictimization. Betrayal, the second trauma-related dynamic mentioned by Finkelhor and Browne (1985), is created when the child victim discovers that the abuser she once trusted has done her harm. A common consequence of the betrayal of the child abuse victim's trust is an inability to correctly judge the trustworthiness of others, which leads to vulnerability to future victimization. The third traumagenic factor suggested by Finkelhor and Browne (1985), is powerlessness, which refers to the manner in which the victim of child sexual abuse has her desires, beliefs and sense of personal power continually violated. This inability to protect oneself from abuse can socialize a child into the role of a victim as an adult. Stigmatization is the last traumagenic factor mentioned by Finkelhor and Browne (1985). This refers to the sense of badness, shame and guilt that often surrounds the sexual abuse experience and is later incorporated into the victim's self-image. Survivors of abuse often feel isolated and different from the mainstream culture which can create a gravitation toward stigmatized activities such

as criminal activity and prostitution that offer a greater risk of revictimization.

Methodological Limitations

Various methodological issues make the examination of the current empirical research concerning revictimization after childhood sexual abuse most indefinite. Definitions of critical variables are often inconsistent among the different studies. External and internal intervening variables make the attribution of direct causality almost impossible to determine. In addition, other methodological concerns such as inadequate sample size, biased sampling and the questionable reliability of self-report instruments are evident within the current empirical literature. Self-reports of past sexual abuse are vulnerable to bias due to the emotions associated with the event, the variability in comfort discussing sexual matters, the tendency to repress and forget sexual trauma and some individual's proneness to interpret sexual situations more negatively (West, 1985).

Inconsistent Definitions

The empirical research tends to have many diverse definitions for childhood sexual abuse. Some literature limits sexual abuse to sexual contact (ranging from touching through intercourse) between a child and an individual at least 5 years older (Briere & Runtz, 1988; Finkelhor, 1979). In contrast, some studies expand sexual abuse to include noncontact experiences (i.e., exhibitionism or being forced to watch someone masturbate), in addition to contact experiences (Wyatt et al., 1992; West, 1985). Others perceive sexual activity to be abusive, regardless of the age difference

between the perpetrator and the victim, if the contact is not desired by the victim or if coercion is involved (Wyatt & Newcomb, 1990; Wyatt et al., 1992).

A variety of methods were used to assess sexual abuse, ranging from direct questioning (Finkelhor et al., 1990) to clinical interviews (Husain & Chapel, 1983) to a standardized questionnaire format, such as the Crisis Symptom Checklist, Traumatic Antecedents Questionnaire, Family Experiences Questionnaire or the Wyatt Sex History Questionnaire (Wyatt et al., 1992; Wyatt & Newcomb, 1990; Briere & Runtz, 1988; van der Kolk, Perry & Herman, 1991).

The age cutoff for childhood is likewise inconsistent throughout the empirical research. Within the literature, childhood sometimes ends at age 14 (Russell, 1987), 15 (Briere & Runtz, 1987; Briere & Runtz, 1988), 16 (West, 1985; Bryer et al., 1987) or 18 (Wyatt & Newcomb, 1990; Beitchman, Zucker, Hood, DaCosta & Akman, 1991; Wyatt & Guthrie, 1992; Jackson et al., 1990; Finkelhor et al., 1990), which complicates making direct comparisons between the studies.

Difficulties Determining Causality

Although revictimization may covary with childhood sexual abuse, it is difficult to determine whether revictimization is solely caused by childhood sexual abuse or also involves some other intervening factors. Several variables have been discovered to correspond with the degree of subsequent damage the child abuse victim suffers. These factors include: (a) the duration of the sexual abuse experience, (b) the age of the victim when abused, (c) the relationship between the victim and the perpetrator, (d) the sex of the offender, (e) the personality structure of the victim

prior to abuse, (f) the presence of aggression or force within the abuse experience, (g) the type of sexual abuse experienced (contact vs. noncontact), and (h) the age of the perpetrator (Wyatt & Newcomb, 1990).

Environmental factors are also significant in determining the effect of childhood sexual abuse. These factors include: (a) the response and the actions of persons told about the abuse, (b) the amount of structure, support and supervision within the family, (c) the amount of adequate sex education, (d) the amount of substance abuse and marital conflict within the family, (e) the amount of family stress, and (f) the support system of the victim (Beitchman et al., 1991; Finkelhor et al., 1990; Wyatt & Newcomb, 1990).

Therefore, the abundance of possible intervening factors makes the task of determining causality between childhood sexual abuse and revictimization extremely complicated. It is difficult to control for the combination of abuse-specific factors and environmental factors that could lead to an increased likelihood of revictimization.

Other Methodological Concerns

Other methodological concerns have been found within the empirical research that decrease the applicability of the studies. One such concern is inadequate sample size within a proportion of the empirical literature. Several studies examined limited populations which led to obtaining samples of fewer than 50 subjects (Herman & Hirschman, 1981; de Young, 1982a; Beck & van der Kolk, 1987; de Young, 1982b). However, the majority of studies had an adequate sample size, ranging from 66 to 1,481 female subjects (Bryer et al., 1987; Briere & Runtz, 1987; Briere & Runtz,

1988; West, 1985; Wyatt & Newcomb, 1990; Finkelhor et al., 1990; Miller, Moeller, Kaufman, Divasto, Pathak & Christy, 1978).

The external validity of the empirical research is limited by some of the biased samples, which include subjects seeking assistance at a sexual assault crisis center, chronically hospitalized psychotic women, university women and psychiatric inpatients (Miller et al., 1978; Beck & van der Kolk, 1987; Briere & Runtz, 1988; Briere & Runtz, 1987; Bryer et al., 1987; Simpson & Porter, 1981). In contrast, several empirical studies took great care through random sampling methods to create a non-biased sample which can be more easily generalized to the entire population (Finkelhor et al., 1990; Wyatt et al., 1992; Wyatt & Newcomb, 1990).

The final methodological concern within this literature is the reliability of the self-report instrument as a true measure of childhood sexual abuse. All of the empirical research relies upon self-report, through either responses to direct questions, clinical interviews or standardized questionnaires, due to the fact that the event in question, childhood sexual abuse, is a past event that cannot presently be observed. However, some self-reports were substantiated by reports from parents or social agencies, hospital and police records or observations of sexual contact between father and daughter (Miller et al., 1978; Atkeson, Calhoun & Morris, 1989; Beck & van der Kolk, 1987).

Comprehensive Long-Term Effects

Revictimization is just one of the many factors that have been related to

childhood sexual abuse. Extensive studies have been conducted to determine the long-term effects of sexual abuse in childhood. These comprehensive long-term effects tend to be psychological, sexual, relational and/or behavioral in nature. Many psychological symptoms have been discovered to be more prevalent in adult survivors of sexual abuse. These include psychotic or psychotic-like symptoms, depressive symptoms, chronic anxiety, dissociative experiences, somatization, impaired self-esteem, borderline diagnoses and character features, and problems with anger (Bryer et al., 1987; Gelinas, 1983; Briere & Runtz, 1988; Jackson et al., 1990; Briere & Runtz, 1987). Sexual dysfunctions that are connected with sexual abuse in childhood include homosexuality, confused feelings about sex, frigidity, promiscuity, sexual delusions and flashbacks during sex (de Young, 1982; McCormack, Janus & Burgess, 1986; Beck & van der Kolk, 1987; Jackson et al., 1990). Childhood sexual abuse can lead to poor social adjustment, difficulties with intimacy and lack of assertion of personal needs and boundaries (Gelinas, 1983; Jackson et al., 1990). Behaviors found to be more prevalent within the sexually abused population include substance abuse, eating disorders, and running away from home (Briere & Runtz, 1987; Beck & van der Kolk, 1987; Whitbeck & Simons, 1990).

Therefore, childhood sexual abuse often has longitudinal effects on the victim. Some sexual abuse survivors feel as if the experience taught them that they have no rights, power, or dignity (Gelinas, 1993). The sexual abuse often distorts the victim's sense of who they are and what sex signifies (Herman & Hirschman, 1981). Victims of trauma have to deal with the psychological damage to their assumptions that they

are personally invulnerable and that the world is comprehensible (Herman & Hirschman, 1981). Sometimes the destruction of these assumptions may give the childhood sexual abuse victim a loss of stability and a vulnerability to being victimized again or victimizing oneself.

Revictimization by Others

Empirical research has documented the prevalence of revictimization following childhood sexual abuse. The adult child abuse survivor is more likely to be perpetually violated than the woman who was not molested in childhood (Blume, 1990). Several factors such as impaired self-esteem, lack of personal power and a tendency to develop exploitive relationships can increase the chance of revictimization (Peterson & Seligman, 1983). This review will examine sexual and physical abuse in adulthood as sequelae to childhood sexual abuse.

Sexual Abuse

Sexual abuse in adulthood includes both contact and noncontact forms of abuse. Contact sexual abuse is comprised of acquaintance and stranger rape, marital rape, sexual exploitation by therapists and sexual advances by authority figures. Exhibitionism and being forced to watch sexual acts are included as noncontact sexual abuse.

Wyatt et al. (1992) administered the Wyatt Sex History Questionnaire, the Rosenberg Self-Esteem Scale, the General Well-Being Scale and the Mosher Sex Guilt Scale to 248 female subjects, ranging in age from 18 to 36 years of age. One-

hundred-fifty-four of these women reported at least one incident of contact or noncontact sexual abuse before age 18. One hundred and twelve of the women reported sexual abuse involving contact and 42 women experienced only noncontact sexual abuse. This study combined both contact and noncontact abuse in the definition of the sample of women abused in childhood. When noncontact sexual abuse was differentiated from contact sexual abuse, there was no significant correlation between noncontact sexual abuse in childhood and unintended and aborted pregnancies or increased likelihood to engage in masturbation, cunnilingus, fellatio, vaginal and anal intercourse and group sex in adulthood. Forty-four percent of the women who experienced contact childhood sexual abuse stated they were subjected to contact or noncontact abuse in adulthood. This study found that women who were sexually abused by contact or noncontact sexual abuse in childhood were 2.4 times more likely to be sexually revictimized in adulthood ($p=.0026$). The women experiencing contact sexual abuse in childhood who were sexually revictimized as adults also had significantly higher rates of unintended or aborted pregnancies ($p=.055$).

It is possible that the survivor's perception of herself as powerless may contribute to difficulties in planning pregnancies and initiating discussions with sexual partners (Finkelhor, 1985). This study supports that noncontact sexual abuse as well as abuse involving physical contact can have negative effects on subsequent adjustment of the victim. However, additional research is needed to confirm the results of this study due to the small sample size of revictimized women and the limitations of the retrospective data.

Another study of 930 adult females focused upon sexual revictimization as an outcome of incestuous abuse in childhood (Russell, 1987). Sixty-eight percent of the incest survivors in this sample later became victims of rape or attempted rape in adulthood. This is a significant difference from the 38 percent of women not sexually abused in childhood who reported a rape or attempted rape experience in adulthood ($p < .001$). Incest survivors were discovered to be 2.5 times more likely to experience marital rape, twice as likely to have unwanted advances by authority figures and twice as likely to be asked to pose for pornography than women never sexually abused in childhood.

In addition, the adult incest survivor is more likely than females never sexually abused to be the target of noncontact sexual abuse, such as exhibitionism (Blume, 1990). This increased likelihood for repeated sexual abuse may stem from the victim's sense of herself as weak, needy, helpless and out of control (Blume, 1990). Some women cope with their incestuous abuse by becoming promiscuous which leads to an increased vulnerability to rape and other sexual assaults (Russell, 1987). Aversion to sex is another common consequence of incestuous abuse that makes the victims more likely to reject unwanted sexual advances which sometimes leads to sexual violence (Russell, 1987).

Another study (Miller et al., 1978) of 341 females seen by the New Mexico School of Medicine Sexual Assault Response Team discovered that of first time sexual abuse victims, four percent reported that this abuse was incestuous. In contrast, recidivist victims reported that 18 percent of their prior abuse was incestuous

($p < .001$). Twenty-four percent of the 341 sexual assault victims interviewed were recidivist victims of sexual assault. The results of this study may be limited by the crisis setting which is not sometimes conducive to sensitive reporting of historical data. This insensitivity to historical information is supported by the fact that in follow-up therapy sessions many victims divulged information about previous sexual abuse for the first time.

De Young (1982a) found that 29 percent in a sample of 48 female victims of incest had been sexually revictimized as adults. In addition, three of the 48 subjects had experienced sexual victimization by either a psychologist or a psychiatrist. This revictimization may in part reflect the incest victim's tendency to sexualize the transference process which makes her more vulnerable to sexual exploitation in therapy. This study is limited by the small sample size and its focus upon incestuous abuse, which is only a subset of the women sexually abused in childhood.

Physical Abuse

Physical abuse within intimate relationships tends to be prevalent among adult survivors of sexual abuse. Physical abuse or battering includes physical harm such as slapping, kicking, punching, biting or attacking with a weapon (Post, Willett, Franks, House, Back & Weissberg, 1980).

Walker (1984) discovered that almost one-half (48%) of a sample of 400 battered women reported they were sexually abused as children. However, high levels of violence in the family of origin and uncontrollable events in childhood were also associated with higher probability of future physical abuse within intimate

relationships. This study also discovered that great family stress and low-income is also correlated with spousal violence. However, the risk of physical abuse within intimate relationships is greatest when all decision making is made by just one of the partners (Walker, 1984).

Another study (Briere & Runtz, 1987) evaluated 152 female walk-in clients at a crisis counseling center. They found that significantly more ($p=.0003$) survivors of childhood sexual abuse (48.9%) were battered as adults than women who were not sexually abused as children (17.6%). This tendency towards physical abuse in adulthood may be due to the child abuse survivors' difficulty with balancing obligation and entitlement in relationships (Gelinas, 1983). This study may not be readily generalizable to the general population due to the sample limitation of females seeking help at a crisis counseling center.

Herman and Hirschman (1981) reported that 11 women in a sample of 40 incest survivors were repeatedly physically beaten by their husbands or lovers. These women felt that they deserved to be beaten and had difficulty recognizing that physical abuse was not a necessary part of relationships. The physically abused women reported spousal abuse in their families of origin and they seemed to be repeating the pattern of their mothers by meekly submitting to abusive, immature and demanding men (Gelinas, 1983; Blume, 1990; Russell, 1987). Russell (1987) substantiated the high prevalence of intimate violence for incest survivors in a study of 930 adult females. Twenty-seven percent of the incest victims in this sample reported that their husbands had physically abused them at least once. Whereas, only

twelve percent of the non-incestuously abused females reported sexual abuse. One obvious limitation of the study done by Herman and Hirschman (1981) is the small sample of 40 incest survivors.

Self-Revictimization

Childhood sexual abuse survivors sometimes cause themselves severe harm and injury through their own voluntary behaviors. Self-revictimization may be inflicted due to a sense of the body as damaged and bad, an inability to manage emotional pain, a tolerance for physical abuse, guilt and hopelessness and an ability to dissociate (James & Meyerding, 1977; Blume, 1990). This review will examine prostitution, self-injury and suicide as forms of self-revictimization carried out by the sexual abuse survivor.

Prostitution

James and Meyerding (1977) conducted a study of 146 prostitutes and discovered that 46 percent admitted to childhood sexual abuse. Parental abuse and neglect is often a typical childhood scenario for prostitutes (Farberow, 1980). Many child abuse victims run away from abuse in the home only to find themselves sexually revictimized. One-third of the females who run away from home in America resort to prostitution soon after they find themselves unable to survive on their own (Blume, 1990). The pimps also give them something familiar in using their bodies to gain the illusion of nurturing (Blume, 1990).

James and Meyerding (1977) also found that 13 of 20 adolescent prostitutes

they interviewed reported having a forced sexual experience when they were 15 years old or younger. Thirty-eight percent of these forced sexual experiences occurred with relatives, mostly fathers. Incest can prepare the victim for prostitution by causing the victim to run away from home, lowering the victim's self-esteem and inhibitions and distorting the victim's view of appropriate sexual behavior (Campagna & Poffenberger, 1988). Incest survivors often have intense hatred toward their abusers and themselves. Therefore, prostitution offers a method to act out this self-hatred and to gain a sense of control over their sexuality at the same time (Campagna & Poffenberger, 1988).

Another study (De Young, 1982b) reported that 8 percent of a sample of 48 female victims of paternal incest had engaged in prostitution. This small percentage of self-revictimization through prostitution may be due to the higher functioning of these women who were attending a university. Academic failure, parental abuse and neglect, emotional alienation, lack of parental supervision, early sexual intercourse and rejection by others due to inappropriate sexual behavior are additional factors associated with prostitution (Brown, 1979; James & Meyerding, 1977).

Self-injury

There is often a significant relationship between childhood sexual abuse and deliberate self-injury which includes skin carving, wrist cutting, biting, burning, eye enucleation, amputation or disfiguring a body part, skin ulceration and genital mutilation (van der Kolk, 1989; Farberow, 1980; Pattison & Kahan, 1983). Self-injury is distinct from suicide in that self-injury involves willful, painful and injurious

actions taken against the body without the intent to kill oneself (Pattison & Kahan, 1983).

De Young (1982a) reported that 57.7 percent of a clinical sample, composed of 45 female paternal incest victims, had engaged in deliberate self-injurious behavior. These self-injurers stated that one reason for injuring themselves was as punishment. This need to punish oneself could stem from the victim's introjection of the abuser's hostility and abuse or be related to self-hatred and hatred of one's body for its involuntary response to the sexual stimulation within the abuse. The self-injurers in this sample stated that the cycle of self-injury begins with overwhelming emotions which lead to a state of depersonalization or numbness prior to the self-abuse.

Another study (Blume, 1990) found that of 250 respondents to a survey on self-injury, 49 percent of the self-injurers stated that they had been sexually abused and 45 percent stated they had been physically abused. Self-injury is often a method to relieve unmanageable stress and to distract oneself from overwhelming feelings of anger, disappointment, fear and rejection. Emotional pain is thereby converted to more manageable physical pain and momentarily the self-injurer may feel more in control.

Van der Kolk, Perry and Herman (1991) followed 74 subjects with personality disorders or bipolar II disorders for four years to monitor their self-injurious behavior. They found that childhood sexual abuse was more strongly related to self-injury than physical abuse or witnessing domestic violence in childhood ($p < .001$). Self-injury has also been related to parental rejection, psychosis, emotional

abandonment and chronic dissociation (Pattison & Kahan, 1983; Green, 1978; van der Kolk, Perry and Herman, 1991).

Suicide

Suicide attempts are another form of self-revictimization prevalent for adult survivors of sexual abuse. Suicide is often the victim's response to loss of power, depression, hopelessness and intense rage toward the abuser and herself.

Herman & Hirschman (1981) reported that 38 percent of a sample of 40 incest survivors had attempted suicide at least one time. Suicide attempts within the incestuously abused population may stem from the victim's deep sense of stigmatization, shame and guilt (Finkelhor & Brown, 1985). Stigmatization is increased if the abuser blames the victim for the sexual abuse, if the victim is unable to disclose about the abuse and if others respond negatively toward the victim when the abuse is disclosed (Finkelhor & Brown, 1985). Adult survivors are also at an increased risk for suicidality due to their sense of being "different" from others, which leads to emotional isolation and lack of support (Herman & Hirschman, 1981).

Another study (Bryer et al., 1987) performed an odds analysis, which involves a logistic regression analysis exploring the relationship between childhood abuse and adult diagnoses, with their sample of 66 female psychiatric inpatients. The authors discovered that subjects with suicidal ideation, gestures and attempts were 3.13 times more likely to have been abused in childhood than subjects without suicidal symptoms. Suicidality may also be related to impaired self-esteem and extreme passivity in getting personal and relational needs met (Gelinas, 1983).

Briere and Runtz (1987) conducted a study of 152 female walk-in clients at a local crisis counseling center. They discovered that significantly more ($p = .03$) sexually abused women (50.7%) had previously attempted suicide than women who had never been sexually abused (33.7%). Suicide is the ultimate form of self-revictimization in which the childhood sexual abuse survivor attempts to permanently re-injure herself and quiet the intense emotional pain created by the sexual abuse.

Clinical Implications

The prevalence of revictimization following childhood sexual abuse influences clinical issues such as assessment and therapeutic interventions. It is essential that therapists receive training in assessing revictimization with clients who have been sexually abused in childhood. Likewise, it is necessary to explore possible childhood sexual abuse with clients whose presenting problems are sexual abuse in adulthood, physical abuse within intimate relationships, prostitution, self-injury or suicide attempts.

An even more prudent assessment approach would be to take a comprehensive sexual history and to ask direct questions regarding childhood physical and sexual abuse, rape, battery within intimate relationships, prostitution, self-injury and suicide attempts as part of the initial psychiatric evaluation of female patients (Wyatt et al., 1992; Coons et al., 1989).

It is imperative that both the abused client and the therapist gain awareness of the connection between childhood sexual abuse and revictimization, because the client

is at greater risk of revictimization without an understanding of how the past sexual abuse affects her current behavior (Wyatt et al., 1992). Revictimized female clients are often compulsively repeating their trauma which leaves them feeling helpless, bad, and out of control (van der Kolk, 1989). Therefore, a primary goal of therapy should be to assist the client to gain control over her life. One method to get back this control is to gain insight into the original traumatizing situation- the childhood sexual abuse. It is essential that the therapist model the appropriate response of a caring, nonabusive adult when the client speaks about the childhood sexual abuse, especially if the client was not supported when she originally disclosed the abuse (Wyatt & Newcomb, 1990).

Other issues which are central with clients who have been sexually abused in childhood are coping skills, sexuality issues, decision-making, expression of needs and dealing with guilt. The revictimized client needs to learn methods to cope with stress and overwhelming emotions without acting out the trauma through being revictimized by others or revictimizing herself. This need for coping skills is especially true for self-injurers. Self-injurers need much support to begin to remain with their feelings rather than detaching from them by self-abuse. Guilt and abandonment rage are often catalysts for self-injury. Therefore, it is important that the therapist be consistently present and give the client positive validation to reduce her excessive guilt feelings (Blume, 1990).

One frequent effect of childhood sexual abuse and subsequent revictimization is a distorted perception of one's sexuality. These clients often need to learn to see

themselves as sexual beings rather than sexual objects (Wyatt et al., 1992). The revictimized woman may have difficulty expressing her sexual needs and boundaries. Therefore, a therapeutic task should be to instruct the client about communicating sexual needs, negotiating with sexual partners about the type and frequency of sex, and contraceptive use. It would also be beneficial to explore with the survivor of sexual abuse in what circumstances she has the most difficulty saying no to unwanted sexual contact (Wyatt et al., 1992). Childhood sexual abuse survivors have a tendency to seek out relationships with men who abuse them. Therefore, issues related to revictimization in relationships need to be explored, including the importance of selecting partners with whom they can share sexual decision making (Wyatt et al., 1992). The ability of the child abuse survivor to assume control over her sexuality and sexual experiences is often central to her healing (Wyatt et al., 1992).

Summary and Implications for Future Research

This review has attempted to evaluate revictimization as a sequela to childhood sexual abuse. The general results of relevant literature suggest that sexual abuse in adulthood, physical abuse within intimate relationships, prostitution, self-injury and suicidality are more prevalent for survivors of childhood sexual abuse than the general population.

However, the current understanding of revictimization following childhood sexual abuse is far from complete. Revictimization is thought by some theorists to

result from desensitization to abuse, a compulsive behavioral re-enactment of the original trauma, a response to the learned helplessness phenomenon or as a result of traumagenic dynamics.

Another difficulty in determining the relationship between childhood sexual abuse and revictimization is the multitude of possible intervening factors. Abuse-specific intervening factors include the duration of the sexual abuse, the age of the victim when abused, the relationship between the victim and the perpetrator, the sex of the perpetrator, the personality structure of the victim prior to abuse, the presence of aggression or force within the abuse experience, the type of sexual abuse experienced and the age of the perpetrator (Wyatt & Newcomb, 1990).

Environmental intervening factors include the response and actions of those told about the abuse, the amount of structure, support and supervision within the family, the amount of adequate sex education, the amount of substance abuse and marital conflict within the family, the amount of family stress and the support system of the victim (Beitchman et al., 1991; Finkelhor et al., 1990; Wyatt & Newcomb, 1990).

Therefore, even though sexual abuse in adulthood, physical abuse within intimate relationships, prostitution, self-injury and suicidality appear to be more prevalent for survivors of childhood sexual abuse it cannot be proven that childhood sexual abuse directly leads to revictimization.

Conclusions regarding revictimization following childhood sexual abuse are also difficult to ascertain due to a limited number of controlled studies. Those studies which included controls normally covered a limited population or had limitations

within statistical analysis. Several studies sampled biased populations, such as psychiatric inpatients, college students, outpatients and street prostitutes, which limits the generalizability of the findings to the general population. The paucity of controlled studies means comparisons have to be made with percentage rates from different studies which tend to have inconsistent definitions of both childhood sexual abuse and revictimization.

Therefore, a better understanding of the relationship between childhood sexual abuse and subsequent revictimization could be obtained if researchers adhered to the following guidelines:

- 1) Obtain consistent definitions for childhood sexual abuse and revictimization.
- 2) Expand the definition of revictimization to include physical abuse within intimate relationships and self-revictimization.
- 3) Include control groups which are matched to sexually abused samples for all relevant social and demographic variables such as age, sex, family configuration and socioeconomic status.
- 4) Include both normal, nonabused controls as well as a control group of psychologically disturbed individuals, such as physically abused children, in order to best test for specificity effects.
- 5) The influence of abuse-specific factors should be controlled for either experimentally or statistically.
- 6) Samples should be of an adequate size to increase the applicability of the study.
- 7) Outcome measures should be utilized to enable the comparison of findings between studies. (Beitchman et al., 1991)

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